Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

NON-PREFERRED ENTERAL NUTRITION

PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____Beneficiary's Medicaid: _____

DOB: _____ City:_____
Month/ Day/ 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ Medicaid ID # _____

City_____ State _____ Phone #: _____FAX:_____

_____
Physician's signature and date

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____Provider: _____

City_____ State _____ Phone #: _____FAX:_____

DRUG/ CLINICAL INFORMATION

Drug Name and Strength: _____ Quantity /Month: _____

Daily dose: _____ Length of Therapy _____

Diagnosis: _____ NDC # _____

Consultation with a Registered Dietician? YES NO Date: _____ Name: _____

******Must attach a copy of the original prescription** ****
Attach lab results and other documentation as necessary

Indicate Method of Administration: Is nutritional requested the sole source of nutrition? YES NO

Oral (by mouth) ☐ Is beneficiary > 21 years of age? YES NO

Bolus or Syringe ☐ Is beneficiary Medicare eligible? YES NO

TPN (total parental nutrition) ☐

Is beneficiary WIC eligible? YES NO

If YES, indicate the monthly quantity supplied by WIC: _____

Children under 5 years of age, pregnant and postpartum women must register with the federal program for women, infants, and children (WIC). If WIC cannot supply all of the beneficiary's needs, Medicaid may authorize additional products. A copy of the completed WIC statement must be attached to this form. NPI :___